APPLICATION FORM FOR SPECIFIED CRITICAL ILLNESS

For Home Office Use Only
ID#
Plan Code:
Effective Date

AIG AMERICAN GENERAL

State of Georgia Flexible Benefits Program

Post Office Box 7308
Columbia, South Carolina 29202 1-866-849-2958

☐ New Hire ☐ Change in status ☐ Date of Event _____

1	Employee Name	Social Security Number		Gender	Date of Birth (age must be 18 – 69)
2	Street Address	City	State	Zip Code	Home Phone Number
3	Beneficiary Name & Relationship				
4	Occupation	Agency / Dept	Date of Hire	Hours worked per week ☐ FT ☐ PT	

5a	Are you now being treated for or ever been treated for: • cancer or any malignancy which includes: melanoma, carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor. (Cancer does not include basal cell or squamous cell carcinoma) ; • a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease); • diabetes, or any liver disorder; • kidney (renal) failure or end stage kidney (renal) disease; • organ transplant; emphysema; • now taking three or more medications for high blood pressure?	**☐ YES ☐ NO**
5b	Have you been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC), or ever been tested positive for antigens or antibodies to an "AIDS" virus?	**☐ YES ☐ NO**
5c	Are you now hospitalized or unable to perform your normal duties and activities?	**☐ YES ☐ NO**
5d	**EMPLOYEE BENEFIT OPTIONS:** **☐ $5,000 ☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000**	

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To the best of my knowledge and belief, the answers to the questions on this application are true and complete. They are offered to American General Assurance Company as the basis for any insurance issued. It is understood and agreed that coverage will not become effective unless I am actively at work on the date of enrollment and the effective date of coverage.

➢ Do you understand and agree that no benefits are payable for loss starting or occurring within 12 months of the effective date of coverage which is caused by, contributed to by, due to or resulting from a Pre-existing condition, unless you have gone 12 months without medical care, treatment or supplies for the Pre-existing condition?
☐ YES ☐ NO

CERTIFICATION: The undersigned applicant has read the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the certificate. I understand that no insurance will be in effect until my application is approved and the necessary premium is paid.
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

I authorize my employer to deduct appropriate amount from my earnings and to deduct and pay to American General Assurance Company the premium required thereafter each month for my insurance.

Date _____ Signature of Applicant _____